THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

OPENING SUBMISSIONS ON BEHALF OF MIND FOR MODULE 3

1. These submissions are made on behalf of Mind. They have been prepared with input from Mind's in-house legal team and external counsel. Mind is the leading mental health charity in England and Wales. It provides information, advice and support to people affected by mental health problems, which can range from those simply seeking someone to talk to, to those who suffer from serious mental health problems that may lead them to be detained under the Mental Health Act 1983.

2. On Friday 13 November 2020 Mind issued an urgent communique, warning that "*the nation is in the grip of a mental health emergency*". Its Chief Executive said that it was a critical moment for the Government to act to prevent a second, mental health pandemic, and called for immediate investment in mental health services in the community and the provision to those most at risk the option of face to face support if they needed it, even in areas with the strictest lockdown restrictions. Far too many people weren't getting the support they needed and were ending up in crisis. Mind identified the personal trauma this was causing individuals, but also the added strain on the NHS, which was simply running out of mental health beds. Mind urged the Government to learn from what went wrong in the first wave of Covid-19 and make sure people could gain prompt access to the help they needed, in order to protect both people's mental health and the NHS. Mind finds itself making the same recommendations today.

3. Mind gathers data from its helplines, local Minds and lived experience volunteers to inform its work, which continued throughout the pandemic. Mind is therefore well-placed to speak to the effect of the pandemic and lockdown on CYP who suffered from a decline in their mental health during the relevant period, many of whom struggled to access services. It receives frequent calls from young people who say they feel misunderstood and ignored by professionals during the mental health assessment process. NHS data shows that one fifth of young people now have a mental health problem compared with one ninth in 2017. Services available through schools and the NHS simply cannot cope with this rising demand for mental health treatment.

The remit of the Inquiry

4. Mind remains concerned that the effects of the pandemic on the provision of care, treatment

and support to *all* people living with mental health problems has been held to fall outside the remit of this inquiry. Mind understands the need for the inquiry to attempt a proportionate focus on areas of greatest concern. At the same time, Mind is uncomfortable with the exclusion of the experience of all people with SMI during the relevant period, which is of particular concern given the strikingly high covid mortality rates of people with SMI.

5. Mind is also concerned that a focus on CYP *inpatient* services will not take sufficient account of the vital need for coordination between inpatient and outpatient services, which, to be effective, should work in tandem to ensure that people with mental health problems receive treatment appropriate to their needs in accordance with the principle of least restriction. Inadequate outpatient services are liable to result in worsening of symptoms and avoidable admissions to hospital. Similarly, the discharge of inpatients to inadequate or absent aftercare is liable to result in avoidable re-admission to hospital; indeed, the core purpose of aftercare is to meet a need arising from or related to the patient's mental health and reducing the risk of a deterioration of the patient's mental condition and thereby the risk of the patient requiring readmission to hospital.

The statutory backdrop to admission and discharge from hospital, leave and aftercare

6. The care, treatment and management of CYP in the mental health system is regulated by statute, principally the Mental Health Act 1983 (MHA) which may authorise the detention of children or young people who need to be admitted to hospital for assessment and/or treatment, when they cannot be admitted and/or treated on an informal basis. Decisions about detention, leave of absence from hospital, and post-discharge aftercare are additionally informed by statutory guidance in the Code of Practice to the MHA prepared by the Secretary of State under s.118.

7. At the heart of the statutory scheme is the *risk arising from the patient's mental disorder*: for example, s.3(2) MHA contains three conjunctive criteria for detention, all of which must be satisfied, and one of which is that medical treatment is *necessary for the protection of the P's own health or safety or for the protection of others*, and cannot be provided unless the P is detained in hospital. If that criterion is not satisfied, then a community patient cannot be admitted, and a detained patient must be discharged. Many CYP inpatients have informal status, i.e. theirs or their parents' consent has been obtained for their admission. Those admissions are regulated by ss.131 and 131A MHA. But for such patients, the same considerations should always apply, i.e. whether inpatient treatment is necessary for the provision of appropriate

treatment and the protection of the CYP from risks to their health and safety arising from their mental disorder.

8. In relation to the detention of CYP on adult wards, s.131A MHA requires that children and young people who are admitted to hospital for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). It does not prohibit all admissions of individuals aged under 18 to adult wards (though in the case of children aged under 16 it is government policy that they should not be admitted to an adult ward). Such admissions are permissible only in exceptional circumstances, which the Code categorises as 'emergency situations' and 'atypical cases.' In all cases, decisions about whether and where to detain require the child's welfare to be the central consideration.

9. Patients may leave hospital under a variety of circumstances including being fully discharged, or on short-term leave, or to receive care and treatment in the community subject to aftercare, which may be imposed by a range of measures. The Code's guidance on the clinical discretion to grant inpatients temporary leave from hospital again puts risk assessment at the heart of the decision-making process. "*Leave of absence can be an important part of a detained patient's care plan, but can also be a time of risk.*" At para 27.10 the Code makes detailed recommendation about the planning of leave of absence, many of which emphasise the potential for peril, and the need for proper planning for risk mitigation and community support.

10. Many discharged patients who have been detained in hospital will be entitled to aftercare under s.117 MHA, which applies to all ages including children and young people, with the purpose of meeting a need arising from or related to the patient's mental disorder thereby reducing the risk of a deterioration of their mental condition (and so reducing the risk of the patient requiring readmission to hospital for treatment). But whether or not s.117 applies, a CYP who has been admitted to hospital may be 'a child in need' for the purpose of s.17 of the Children Act 1989.

11. The Code emphasises the importance of advance planning for aftercare, which should start as soon as the patient is admitted to hospital. ICBs, LHBs and local authorities should take reasonable steps, in consultation with the care programme approach care co-ordinator and other members of the multidisciplinary team, to identify appropriate after-care services for patients in good time for their eventual discharge from hospital. Before deciding to discharge or grant more than very short-term leave of absence to a patient or to place a patient on a CTO, the responsible clinician should ensure that the patient's needs for after-care have been fully

assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan. If the patient is being given leave for only a short period, a less comprehensive review may be sufficient, but the arrangements for the patient's care should still be properly recorded.

The pandemic's impact on Children and Young People with mental health issues

12. During the relevant period, the UK suffered a secondary pandemic of deteriorating mental health. CYPMHS were already overburdened. The pressure of the pandemic highlighted that and exacerbated it. That the pandemic would strain to breaking point a MHS that was already under resourced was predictable and foreseeable, but there was no specific plan to address it. According to the expert report of Dr Guy Northover and Dr Sacha Evans "*The UK Government had developed a pandemic response plan in previous years. This was initially developed in 2011 as the UK influenza Pandemic Preparedness Strategy in collaboration with the devolved governments.* ***There were no specific plans in place for mental health inpatient services in the UK's pandemic preparedness despite the likely serious toll on everyone's mental health due to social isolation, anxiety, financial stress and grief. No consideration was given to the impact on children and teenagers, who would face disrupted schooling and social isolation***." [our emphasis]. There was early recognition of the risks of worsening mental health as a result of the pandemic in May 2020[1]. People with mental health conditions were identified as vulnerable, as were vulnerable children. Poor or worsening mental health was also identified as a manifestation of vulnerability, along with difficulties accessing medicine/care/support services and/or delays to treatment and increased risk of harm from self-harm, exacerbation of existing conditions, or delayed presentation of new health concerns. The risks to CYP in mental health crisis as a result of the pandemic and its management were identifiable.

13. Those early warnings were borne out. People with protected characteristics all fared disproportionately badly in the deterioration of their mental health during the pandemic, but those who suffered most of all were those people with pre-existing mental health conditions.[2] People with SMI were almost 5 times more likely to die during the pandemic than people without SMI[3]. The increase in premature mortality for people with SMI during the pandemic was particularly high in London and the North East, linked to high levels of deprivation and/or

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[1] Submission by Department of Health and Social Care to Secretary of State for Health and Social Care, regarding vulnerable groups and Covid-19, dated 19/05/2020 at p6 [Annex A] "Other forms of vulnerability indirectly related to COVID-19 (Category 2)".

[2] Mind, *The mental health emergency: How has the coronavirus pandemic impacted our mental health* (2020); Mind, *Coronavirus: the consequences for mental health* (2021)

[3]Office for Health Improvement & Disparities, *Premature mortality during Covid-19 in adults with severe mental illness* (19 October 2023)

proportions of people from racialised groups. CYP in the lowest income bracket are 4.5 times more likely to experience severe mental health problems than those in the highest. More than twice as many people in Wales (aged 16+) experience mental health problems in the most deprived quintile (16%) than the least deprived quintile (7%)[4]. In its '*Not making the grade'* report (2021), Mind found that existing inequalities in housing, employment, and income had a greater impact on the mental health of people from racialised communities than white people during the pandemic. People from racialised communities were more likely than white people to be referred to mental health services via 'involuntary' routes including social services and criminal justice than they through 'voluntary' routes such as their GP.

14. The pandemic, and the resultant increased vulnerability of CYP to deterioration in their mental health, or worsening of pre-existing mental health conditions, occurred in the context of a CYPMHS that was already recognised to be so significantly flawed that it was in numerous cases unfit to achieve its purpose. In 2017, in Re X (A Child)(No.3) [2017] EWHC 2036 (Fam) at [37], Sir James Munby, then President of the Family Division, added these strong words to what had already become a matter of judicial comment in previous cases:

    "[37] *What this case demonstrates, as if further demonstration is still required of what is a well-known scandal, is the disgraceful and utterly shaming lack of proper provision in this country of the clinical, residential and other support services so desperately needed by the increasing numbers of children and young people afflicted with the same kind of difficulties as X is burdened with. We are, even in these times of austerity, one of the richest countries in the world. Our children and young people are our future. X is part of our future. It is a disgrace to any country with pretensions to civilisation, compassion and, dare one say it, basic human decency, that a judge in 2017 should be faced with the problems thrown up by this case and should have to express himself in such terms.*"

15. Similar expressions of judicial exasperation continued to be made during the relevant period. This suggests two important things. First, the long-term nature of failings in the CYPMHS and associated services. Second, that it could and should have been foreseeable that a failing sector of the health service would be further stressed by the onset of a public health emergency. This statement of long-standing judicial concern about CYPMHS provides essential contextual background to the evidence about how the service coped after the onset of the pandemic.

[4] Mind, *Coronavirus the consequences for mental health in Wales* (2021)

The lived experiences of CYP and their families

16. Perhaps the most important feature of the evidence provided by Mind is the accounts of people living with mental health issues during the pandemic. Their voices represent the human experience behind the many statistical and policy analyses.

17. The statement of Julie Pashley describes the impact of the pandemic – and the institutional response to it - on one family. Her daughter CB is a vulnerable young person whose mental health difficulties were severe enough to warrant her being a psychiatric inpatient during the relevant period. On 18th March 2020 CB was a 16-year-old child inpatient. Ward staff suspected she had swallowed a blade. CB's parents were asked to collect their daughter from hospital and take her to the nearest A&E. They were told that because CB was leaving the ward, she could not return for two weeks in case she contracted Covid. CB tested negative for Covid in A&E, so her parents took her back to the psychiatric hospital and asked that she remain there: they were uncomfortable taking her home for unplanned leave. But the unit didn't agree. Ms Pashley records that no document was given to her explaining why CB was being sent home, and as far as she was aware no formal risk assessment had been conducted. This was despite her daughter being "extremely vulnerable" and "actively suicidal" at the time. On 19 March 2020 CB ran away from the family home with the intention of jumping off a bridge. She survived, but her parents were then met with the hospital's refusal to admit her: "*We were on the phone to the Tier 4 inpatient CYPMHS* hospital […] *for a long time that night, but they refused to admit her out of fear that she had Covid.*" The police who attended CB at the bridge then sought to compel the hospital to assess her by detaining her at the police station under s.136 MHA; that worked, and the hospital eventually agreed to re-admit CB.

18. The significance of CB's story to this Inquiry may seem minor – it's just a single incident which happened at a time when millions were undergoing their own struggles. But it serves as an example of a failure, within the context of pandemic response, to assess or give sufficient weight to the risks arising from mental disorder, which in this case nearly led to a vulnerable child losing her life. CB was an inpatient *because* she was acutely vulnerable. A primary purpose of the admission was to protect her. But because of a decision-making process that resulted from the hospital's response to the pandemic, her vulnerability increased, thereby achieving the precise opposite of the purpose of her inpatient care and treatment. Her story speaks to a disorderly decision-making process during the pandemic, in which the acute risk to CB's life was overridden in favour of the blanket application of pandemic management measures.

19. Mind says that this is a scenario that should not be allowed to recur. And more generally, even disregarding the effects of delayed or inapt care on individuals CYP (which can be grave), it is plainly logical in relation to resource allocation to provide support early to prevent the development of more serious issues which are likely to require more intensive and longer-term care and treatment. Thus, Mind maintains, the interests of CYP with mental health issues and the interests of efficient resource allocation are in alignment: both favour prompt assessment of need and provision of care and treatment that is appropriate to the individual's needs.

20. It is important to understand that there is no such thing as a typical experience of psychological vulnerability – every person's experience is unique. But CB's story and other personal accounts of mental health care during the pandemic are instructive, in that they are echoed in research. In 2020, Mind surveyed 1,917 young people to gain insights into the impact of Covid-19 on their mental health. The findings, published in the CV19 Mental Health Emergency report (2020), showed that 75% of YP with experience of mental health problems said their mental health had got worse during lockdown. YP were more likely to find it difficult to access mental health support and were less likely to feel comfortable accessing it over the phone or video-call. YP were most likely to use negative coping mechanisms, with 32% of YP reporting self-harming to cope with the lockdown, making them more than twice as likely to have coped by self-harming than adults (14%).

21. Similarly, Mind's report on The Consequences of Coronavirus for Mental Health (2021), which included insights from 1,756 YP, showed that 18% of YP experienced mental distress for the first time during the pandemic, and nearly nine in ten (88%) reported that loneliness caused by the lockdown worsened their mental health. Despite this, 42% of YP who accessed mental health services had to wait three or more months to get support, and over a quarter (27%) had to wait more than four months.

22. In Mind's report 'Our Rights, Our Voices: Young People's views of fixing the Mental Health Act and inpatient care' (May 2023), YP highlighted serious failings in hospitals that placed them at risk of harm, for example, being routinely placed in adult wards far from home, lack of staff, not being given adequate information about their rights, and being unnecessarily medicated and placed in restraints. 69% of CYP said their experience of inpatient care was poor and consisted of multiple admissions, and 45% of CYP said they had been detained at least five times. Over 80% of CYP surveyed wanted more say in decisions about their care and treatment

plans, saying they felt "bypassed" and "disempowered" in their own care. The report highlighted further areas of concern in CAMHS, including the lack of appropriate support in the community. One YP shared: "*Use of sectioning for young people with autism or similar learning difficulties needs to change. It did more harm than good. It kept me alive, but it wasn't an appropriate place for me to be. The alarms, the banging, the screaming and restraints are absolutely awful for anyone to go through – but especially a young person with autism. The staff need more training on autism and special needs, and the system desperately needs changing.*"

23. That research chimes with research conducted by the Care Quality Commission and the DHSC. The CQC's report *Monitoring the Mental Health Act in 2021 to 2022* (2022), shows a 32% rise in the number of under-18s being admitted to adult wards between 2020/21 and 2021/22, due to lack of alternative mental health inpatient or outreach service available for young people. The report says that "*The impact of the Covid-19 pandemic on Children and Young People's mental health (CYPMH) services continues to be felt, with services struggling to meet rising demand…This is increasing the risk of children and young people ending up in inappropriate environments, such as general children's wards.*"

24. Mind says that what is needed is a comprehensive mental health plan to address the consequences of another pandemic to CYP (and indeed all people) who are likely to struggle with their mental health. If this Inquiry is to achieve its aim, then failures such as in CB's case must inform the lessons to be learned.

25. The category of CYP with mental health issues is extremely diverse: it ranges from CYP who need occasional outpatient support to those who, for a time at least, need admission to highly structured inpatient units. Mind's core proposition is that every one of those CYP should receive individualised assessment, treatment and support which is appropriate to their needs, and in a timely manner. This generation of CYP are probably more sensitive to the perils of disregarding one's mental health than any before it. It is a matter for concern that this generational progress in insight is not always matched by services that are capable of responding.

26. Mind's research has found that CYP were particularly vulnerable to the impact of the pandemic. They were the most likely to use negative coping mechanisms, with 31% reporting self-harming to cope with lockdown restrictions, making them more than twice as likely to have coped by self-harming than adults over 25. They were the least likely to feel comfortable with remote

support. Almost a quarter of all CYP surveyed did not feel their struggles warranted seeking support for their mental health during lockdown, and some of those who did faced attenuated or absent services and cancelled appointments. One year later, in 2021, Mind's follow up research found the decline in people's mental health had become more severe, with over half of young people saying their mental health had got much worse since the first national lockdown. Again, CYP were most likely to use self-harming and under- or over-eating to cope with the pandemic. 42% of the young people who accessed mental health services told us they had to wait several months to get support.

27. Mind suggests there is likely to be a causative link between the difficulties CYP had in accessing support in 2020 and the deterioration in CYPs mental health in 2021. This point is relevant to the Inquiry's terms because as a matter of policy (and common sense), systemic failures to address early signs of vulnerability to mental ill-health by the provision of appropriate and timely support and treatment are likely to result in increased demand for inpatient services further down the line; problems that go unaddressed worsen, and risks to CYP increase. Ensuring the availability of early and timely support, care and treatment for CYP suffering from a decline in their mental health is therefore a vital aspect of preparedness for future pandemics. As Mind's Chief Executive Officer says at para 71 of her statement, "*one learning for a future pandemic must be ensuring there are well-funded and joined-up services providing social, health and education support so that young people can feel secure when they return home. Improved resources could also facilitate better communication and input from different teams*."

28. That overarching analysis of the problems that face the CYPMHS, and of the urgent need for them to be addressed, aligns with the statement of judicial concern described above at para 14, and with institutional analyses. Sir Stephen Powis in his statement on behalf of NHS England dated 31 May 2024 says that it has long been recognised that CYPMHS in-patient services require reform [para 1666]. This is in the context of an increasing need for those services: [paras 1642-1644]. There was an approximately 50% increase in the prevalence of mental health conditions amongst 5–16-year-olds, across all sex and ethnic groups from 2017 to 2020. The pandemic saw further acceleration of that increase, from 1 in 10 CYP experiencing a mental health problem in 2019 to 1 in 6 in 2020, by which time 20% of 17–22-year-olds were identified with "probable mental disorder". It is notable that vulnerable young people were disproportionately affected by those increases, especially those with special educational needs

and disabilities and those living in areas of high deprivation. Mind has long sought to draw attention to the link between disadvantage and vulnerability to mental health problems.

29. This increase in need coincided with an increase in discharges of CYPMHS inpatients immediately following the onset of the pandemic, and there was a decline in admissions to below pre-pandemic levels for the rest of the relevant period. This may have reflected reduced bed capacity caused by staff shortages. As CYPs mental health needs grew during the pandemic, the availability of inpatient services decreased. Similarly, the average length-of-stay and wait times for in-patient CYPMHS admission increased, which reflected an increase in illness acuity and complexity and/or a lack of available provision from community and local authority providers, leading to delayed discharges. Again, increasing need coincided with decreasing availability of both inpatient and community resources to meet that need, and lack of adequate provision of the latter had a knock-on effect on the availability of the former. This speaks to a system in urgent need of enhanced provision.

30. In relation to CYPs lived experience of inpatient services, the picture is no better. Mind's report *'Our Rights, Our Voices'* (2023) was based on the experiences of hundreds of CYP who were admitted to hospital in England and Wales for their mental health treatment when they were under 18, between April and May 2022. There were multiple concerns about the quality of care and treatment, including discharge from services and placement without appropriate support or communication becoming more acute at the height of the pandemic, a dangerous practice that greatly increased distress and risk of harm. This resonates with CB's story recounted above, which indicates the severity of the potential harm that follows inadequately supported discharges from hospital.

Mind's concerns related to CYP inpatient services

31. Mind has long campaigned for recognition that mental health services are the poor relation of the health sector in terms of resource allocation. In broad terms, the pandemic highlighted and heightened, rather than created, many pre-existing inequalities. At the same time, the response to the pandemic also created new issues for CYP trying to get appropriate assessment, care and treatment in a timely manner. The result was that many did not get any or adequate support, with the inevitable consequences of deterioration in their mental health, exposing them to an increased risk of harm.

32. There follows a summary of Mind's concerns in relation to inpatient treatment of CYP during the relevant period. They are primarily sourced from the direct lived experience of CYP in the MHS. They suggest an imbalance in the assessment of competing sources of risk, with risk assessments (where they were conducted at all) weighing heavily in favour of pandemic management and insufficiently in favour of the risks to the individual patient as result of their mental disorder. Whilst it was of course important that patients were protected from infection, it was equally important that they received protection from their vulnerability to self-harm, suicide, and deterioration in mental health.

33. Delays to admission to hospital of CYP in mental health crisis. "*The time taken from the decision [to admit], to being admitted onto a psychiatric in-patient ward increased substantially during the period of Covid-19. This was due to reduced bed availability, confirming the patient's physical health, such as Covid-19 status checks, and increased staffing challenges for patient reviews*" (Northover and Sachs report, para 89). The same report records at para 107 that "*there was a significant increase in the average wait time between referral and admission, increasing from an average median of one to two days wait to a peak of 111 days wait in the last quarter of 2021/22 (NHS England Digital, 2024)*". A need to assess a CYP for admission to hospital is indicative of a potentially severe need for treatment and risk management.

34. Long-term confinement of patients to their rooms on a ward, and inadequate monitoring for the physical health consequences of mental disorder. One young person who was an inpatient during the relevant period described what happened when *"[The] whole ward had covid - everyone alone in room for 2 weeks, food left outside door, no conversation at all for the duration, bedroom stripped* so *nothing to do. Staff not noticing risk behaviour, eg I flushed my food down toilet, was written down I'd eaten as plate was empty, didn't drink for 4 days toward end* of *isolation and ended up in critical condition as no one knew (1day without fluids actually being 5 etc). No physical health monitoring during the 2 weeks - no way to monitor the effects my eating disorder* was *having on my body.*"

35. Discharges without any/adequate community support (leading to heightened risk to the discharged CYP and swift readmission); premature and/or unplanned discharges and extended leave away from hospital, often announced and implemented at short notice and without clear communication. In February and March of this year Mind conducted a mini survey of members of the British Association of Social Workers who support young people in CYPMHS. 35% of

those surveyed said they *frequently* observed inappropriate discharge from hospital during the relevant period. One response recorded that "*the practice of discharging people from hospital without a proper social care assessment became the norm, [as] did an indifference to the risks .... It was hard to believe and was in direct conflict to best practice or social work values.*" This professional experience chimes with the personal stories Mind has been told by CYP and their parents. And the consequences of precipitate discharge could not be more grave: there were an estimated 180 deaths by suicide in the three months after discharge from inpatient mental health services in 2019. The highest risk was in the first two weeks after discharge, with the highest number of deaths occurring on the third day after discharge[5] .

36. Mind has been told by CYP inpatients that they were discharged from hospital with no support plan in the community. This failure of cooperation between state agencies responsible for the care and treatment of CYP has often been identified as of pressing importance: In Blackpool BC v HT (A Minor) [2022] EWHC 1480 (Fam), MacDonald J at paragraph [19] said: "*The courts have repeatedly emphasised the need for the State agencies engaged in cases of this nature to work co-operatively to achieve the best outcome for the child or young person. Within the context of the question of whether a child or young person should be provided with a placement by the local authority or with Tier 4 CAMHS provision, it is vital that local authorities, Clinical Commissioning Groups (which are responsible for commissioning CAMHS services for children and young people requiring care in Tier 1, Tier 2 or Tier 3) and NHS England (which is responsible for commissioning Tier 4 CAMHS services) recognise the emphasis that is placed by the courts and in the guidance on co-operation between State agencies.*" Mind calls on the Government to urgently introduce a statutory process to ensure multi-agency planning for discharging CYP from inpatient settings.

37. Blanket restrictions on or termination of CYP inpatients contact with their family and disproportionate visiting restrictions. After NHS Wales and NHS England announced a national suspension of hospital visits in March 2020 and April 2020 respectively, CYP inpatients were denied access to family contact for up to five months. The impact of the cessation of face-to-face visits due to Covid restrictions was raised as a concern by the coroner during the inquest into the death of 17-year-old Chelsea Mooney, who died by suicide at Cygnet Hospital, Sheffield, in April 2021; the Coroner considered that impact as having been underestimated particularly for young people like Chelsea. Face-to-face visits provide an opportunity for the

[5] British Journal of Psychiatry, 'Suicide and other causes of death among working-age and older adults in the year after discharge from in-patient mental healthcare in England: matched cohort study'(2022)

inpatient clinical team to physically interact with the patient and their loved ones, which is likely to facilitate better communication and relationships between staff, children and their parents. According to the National Institute for Health and Care Research Themed Review, such therapeutic alliances are the strongest predictors of good clinical outcomes in inpatient settings. This is a further instance of a blanket response to the pandemic having an effect that is inimical to the purpose of the inpatient admission.

38. Inadequate inpatient care and safeguarding. Dr Sarah Hughes has described (at paras 49-52 of her statement) her concerns about the safety of CYP in inpatient units, and in particular at private sector hospitals. At para 1730 of the witness statement of Sir Stephen Powis on behalf of NHS England it is recorded that around 38% of CYPMH inpatient provision is in the independent sector, and that "*there has been significant volatility within the CYP independent sector market, specifically*". It is not clear what volatility means in this context, nor what it signifies, nor how it impacted on the provision of mental health services to CYP during the pandemic. Given that the sector represents such a large part of the total service, and given the content of Dr Sarah Hughes' witness statement, the nature and effects of this significant volatility requires further investigation. Mind has long been concerned about the reliance on the independent sector for the care and treatment of acutely vulnerable CYP. That a sector providing 38% of CYP inpatient services was (and may still be) undergoing volatility is a cause for concern.

39. Increasing isolation, including the detention of CYP far from home and family. Isolation is usually counter therapeutic. The response to the pandemic increased it for CYP inpatients in diverse ways. In *'Our Rights, Our Voices*' one of the serious failings identified was CYP inpatients being routinely placed in wards far away from home and family, thus restricting or eliminating direct contact between CYP and their family. Obviously, lockdown travel restrictions worsened the problem. CYP are still being placed in hospitals far from home despite the UK Government saying it would stop placing under 18s 'out of area' by 2020/21, see page 12 in Mind's *'Our Rights, Our Voices'* report. Such placements can contribute to CYP becoming further harmed and traumatised, and in some cases, dying; for example, the out of area placement of Lauren Elizabeth Bridges was listed in her coroner's report as contributing to the deterioration in her mental health that led to her death at Priory Hospital in February 2022.

40. The detention of vulnerable CYP on adult wards. According to the Code of Practice to the MHA, young people should only be admitted to adult wards in exceptional circumstances, but

CQC data shows a 32% rise in the number of under 18s being admitted to adult wards between 2020 to 2022, the "main reason" for which being the lack of "*alternative mental health inpatient or outreach service available for young people*". This suggests that there was often no clinical rationale for the admission of children to adult wards. The steep increase in the use of inappropriate placement of CYP on adult psychiatric wards further suggests a failure to allocate sufficient resources to provide for one of the most vulnerable sectors of society. Section 131A MHA expressly requires that where a person who is under 18 is admitted to hospital (either by detention or informally) the managers of the hospital "*shall ensure that the patient's environment in the hospital is suitable having regard to his age (subject to his needs).*" Mind deprecates the placing of children on adult psychiatric wards as a result of an inadequately resourced CYPMHS.

41. The inappropriate use of and over-reliance on remote consultations, assessments, and treatment. Remote interaction with CYP seeking help for mental health problems formed a key part of the pandemic response. However, the effectiveness of remote contact has been repeatedly questioned in the courts, and by CYP themselves. In Devon Partnership NHS Trust v Secretary of State for Health and Social Care [2021] EWHC 101 (Admin) and Derbyshire Healthcare NHS Foundation Trust v Secretary of State for Health And Social Care (Rev1) [2023] EWHC 3182 (Admin), the High Court refused to declare that remote assessments for the purposes of assessing whether a person required detention in hospital for treatment were lawful, absent express legislative authorisation. In Devon at [60] the Divisional Court observed that *"[...] the fact that the Code of Practice requires physical attendance and that the Secretary of State's Guidance makes clear that in person examinations are always preferable seem to us to show that, even today, medical examinations should ideally be carried out face-to-face.*" That guidance was revised in May 2020 to include, in a section drafted jointly by NHS England and the Secretary of State headed "*Application of digital technology to Mental Health Act assessments*", this statement "*Even during the COVID-19 pandemic it is always preferable to carry out a Mental Health Act assessment in person.*" Assessment in that context means assessment of whether a person has a mental disorder which necessitates their compulsory admission to hospital for treatment. Reliability in assessment is a priority because the consequences of a mistake are potentially grave: either that a vulnerable person does not get the treatment that they need, or that they are unnecessarily made subject to a serious interference with their rights. But reliability must be equally important in the wider context of the care and treatment of vulnerable CYP.

42. In Mind's report *'Trying to Connect: The importance of choice in remote mental health services'* (2021), CYP who had tried to use remote support felt that they were not able to talk openly about their mental state. A Mind IMHA working in Rochdale reported that CYP, especially those with eating disorders, had said they were able to hide their issues better when doing only virtual visits with their community workers, so they were past crisis point when they finally got admitted to hospital. Remote assessment and treatment that is inimical to its purpose is plainly a matter of great concern. And "*Especially with eating disorders*" rings an alarm bell: referrals for CYPMH eating disorder services skyrocketed during the relevant period (Dr Hughes para 66). Early in the pandemic the Royal College of Psychiatrists reported that "*Our members in the front line are reporting significant reductions in patient referrals - especially in child and adolescent services. Those who fail to get the help they need now, will inevitably become more seriously ill. This is particularly concerning for deadly mental health conditions such as Eating Disorders, which have a higher mortality rate than many cancers.*" The routine use of remote means to achieve what was previously done in-person involves serious and foreseeable risk that it will fail those it is intended to protect, with the gravest of consequences. Remote interaction with CYP patients should not be regarded as panacea in pandemic response, nor should it be used as a blanket response to limited resources.

43. Mind's CEO has made detailed recommendations for improving CYPMHS in her witness statement. In short summary, Mind agrees that the CYPMHS sector as a whole has long been in need of reform and urges the government not to stray from commitments to increase the resources allocated to it. The need is not only in relation to inpatient services, which represent one end of a spectrum of services that should be available to CYP when they need them; adequately resourced community MHS are a vital part of what should be a cohesive system by which to provide CYP in mental health crisis with timely intervention, and to ensure that CYP patients who have been discharged from inpatient services get the aftercare that they need to promote sustained recovery and avoid readmission. This represents an alignment of interest between CYP in mental health crisis and the efficient allocation of resources. The broad lesson must be that without significant investment in CYPMHS the same systemic vulnerabilities will recur in the event of another pandemic, resulting in the exposure of a uniquely vulnerable sector of society to unnecessary and grave risks. Along with investment, there is a need for an overarching and comprehensive mental health plan to address the consequences of a pandemic and the measures that are taken to control it.

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